

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
SPENDDOWN PAY-IN
AUTOMATIC WITHDRAWAL AUTHORIZATION
(START, CHANGE, OR CANCEL)

Please allow 30 days for automatic withdrawal to start/change/cancel. When the automatic withdrawal is effective you will not receive a monthly invoice. Continue to pay the monthly invoices you receive until then. If you need help filling out the Automatic Withdrawal form, or to verify the effective date, call toll free at 1-877-888-2811.

- ☐ Start I want the Missouri Department of Social Services to withdraw the Spenddown Pay-In from my account.
- ☐ Change I want the Missouri Department of Social Services to change automatic withdrawal to the bank account named below
- ☐ Cancel I want to cancel the automatic withdrawal of the Spenddown Pay-In.

Part A - Account Information

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

- Check the box that tells if you are using a checking account or a savings account.

- ☐ Checking (Attach a blank check with VOID written across it.)
- ☐ Savings (Attach a savings deposit slip showing your account number with VOID written across it.)

Bank Routing Number - Write your financial institution's routing number printed at the bottom left portion of your checks or deposit tickets (the first 9 numbers).

Bank Account Number – Write the account number printed on the bottom of your checks following the routing number. It may be the first numbers after the routing number followed by your check number (example 1), or the numbers that follow your check number (example 2). (See examples on page 2) The check number is NOT part of the account number.

Bank Routing Number _ _ _ _ _ Bank Account Number _____

Name of Financial Institution _____

Address of Financial Institution (Street) _____

(City) _____ (State) _____ (Zip Code) _____

Financial Institution Telephone Number (_ _) _ _ _ - _ _ _ _

Mail both pages of the Automatic Withdrawal Authorization form to: Division of Medical Services, Financial Services Unit, P.O. Box 6500, Jefferson City, MO 65102-6500.

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Part B – Agreement

I hereby authorize the withdrawal of the spenddown pay-in on or around the 10th of each month from my checking or savings account with the financial institution indicated above. I understand that the spenddown pay-in amount will vary monthly based on family size and income, and authorize continued automatic withdrawals. Withdrawals will be made monthly unless I choose to terminate this agreement. I understand that the Division of Medical Services will make a reasonable effort to complete this transaction in a timely manner. I recognize that it is my responsibility to have the funds available in the account indicated above for the withdrawal of my monthly spenddown pay-in.

SIGNATURE OF

CLIENT _____ DATE _____

Telephone Number (_ _ _) _ _ _ - _ _ _ _

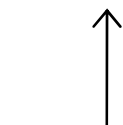
Part C – Customer Information

Case Number _ _ _ _ _ Name _____

Telephone Number (_ _ _) _ _ _ - _ _ _ _

Example 1

FINANCIAL INSTITUTION CHECK NO. 1234 HOMETOWN, USA		
PAY TO THE ORDER OF _____		
123456789	8765432109812	1234



ROUTING #



ACCOUNT #



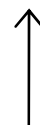
CHECK #

Example 2

FINANCIAL INSTITUTION CHECK NO. 1234 HOMETOWN, USA		
PAY TO THE ORDER OF _____		
123456789	1234	8765432109812



ROUTING #



CHECK #



ACCOUNT #

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